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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 11
6010.54-M
SEPTEMBER 29, 2004

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: **COMBO CHANGE PACKAGE**

PAGE CHANGE(S): See pages 2 through 7.

SUMMARY OF CHANGE(S): This change includes standard of care changes; adds 2003 and 2004 CPT coding changes; updates the AMA 2004 CPT copyright statement; adds sections Chapter 2, Section 6.2 (Neonatal and Pediatric Critical Care Services) and Chapter 8, Section 2.4 (Cold Therapy Devices for Home Use); revises Chapter 7, Section 8.1 from Audiology Services to Special Otorhinolaryngologic Services; adds "TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period Medicare is primary payer and has authorized the care. Once Medicare inpatient mental health benefits have been exhausted, TRICARE's preadmission and continued stay requirements apply." Notes are added clarifying that psychological testing and pharmacologic management are to be considered diagnostic/routine medical services and should not be treated as psychotherapy services. The applicable Prime copayment should be $12 per service rather than $25 per service. Numerous corrections/revisions/updates are added to Chapter 12 (TRICARE Overseas Program). See the Summary of Changes, pages 8 through 15.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 17.

Barbara J. Gallegos

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Director, Office of Medical Benefits and Reimbursement Systems

ATTACHMENT(S): 298 PAGE(S)
DISTRIBUTION: 6010.54-M

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1 (**Rare Diseases**). Adds "Case-by-case review is not required for drugs, devices, medical treatments and procedures that have already been established as safe and effective for treatment of rare diseases."

2. Section 6.1 (**Nonavailability Statement (DD Form 125) For Inpatient Care**). Revises NOTE after paragraph III.H. to "parent/family member."

3. Section 7.1 (**Special Authorization Requirements**). Adds effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. Once Medicare inpatient mental health benefits have been exhausted, TRICARE's preadmission and continued stay requirements apply.

CHAPTER 2

4. Table of Contents (**Evaluation And Management**). Adds Section 6.2 (Neonatal and Pediatric Critical Care Services).

5. Section 1.1 (**Office Visits**). Adds CPT codes 90801 and 90802. The CPT code range is 90801, 90802, and 99201-99215.

6. Section 2.1 (**Home Services**). Adds CPT codes 99341-99350 and 99600-99602 to non-physician's code range. Adds HCPCS codes G0151-G0154 and G0156 to non-physician code range. CPT codes 99539, 99551, 99552, 99553, and 99554-99569 deleted. Non-physician code range: 90801, 90802, 90804-90815, 90847, 90862, 99341-99507, 99511, 99512, 99600-99602, G0151-G0154, and G0156. CPT code for home visit, sleep studies in EXCLUSIONS, paragraph V.A. changed to 95806. EXCLUSIONS, paragraph V.D. changed to home infusion for tocolytic therapy.

7. Section 6.2 (**Neonatal and Pediatric Critical Care Services**). Adds new section to be consistent with the format of the CPT Manual. Adds two new CPT codes, 99293 and 99294, for Pediatrics Critical Care. Adds a new code 99299 for Intensive (Non-Critical) Low Birth Weight Services. The CPT code range is 99293-99296, 99298, 99299.

8. Section 10.1 (**Physician Standby Charges**) adds new CPT codes 99026 and 99027.

SUMMARY OF CHANGES (Continued)

CHAPTER 4

9. Section 1.1A (**Category III Codes**). Category III codes 0002T and 0025T were deleted from procedure code range. New Category III codes 0045T - 0061T, were added to procedure code range, effective January 1, 2004. New Category III codes 0062T - 0074T that were released on January 1, 2004, are also included in the new code range but are not effective until July 1, 2004. The new procedure code range is 0001T, 0003T - 0024T, and 0026T - 0074T.

10. Section 6.1 (**Musculoskeletal System**). New CPT codes 20982 and 21685 are within current procedure code range. Adds new CPT codes 22532 - 22534 to procedure code range. New procedure code range is 20000 - 22505, 22532 - 22534, 22548 - 29902, and 29999.

11. Section 9.1 (**Cardiovascular System**). Adds CPT codes 33140 and 33141 to covered procedures. New CPT codes 33215, 33224-33226, 33508, 34805, 34833, 34834, 35510, 35512, 35522, 35525, 35572, 35697, 36416, 36511, 36555-36558, 36560, 36561, 36563, 36565, 36566, 36568-36571, 36575, 36576, 36578, 36580-36585, 36589, 36590, 36595-36597, 36838, 37182, 37183, 37500, 37501, 37765, and 37766 are within current procedure code range. The new CPT codes 34900, 93580, and 93581 are considered unproven; therefore, these codes are not covered under TRICARE at this time. Removes exclusion of transmyocardial laser revascularization (TMR) (CPT codes 33140 and 33141) and adds coverage of TMR. Adds the following exclusion: percutaneous myocardial laser revascularization (PMR). New procedure code range: 33010-33130, 33140, 33141, 33200-34834, 35001-37799, 92950-93572, 93580-93744, and 93797-93799.

12. Section 9.3 (**Intracoronary Stents**). Adds HCPCS procedure codes G0290 and G0291 (drug eluting stents). Removes exclusions of coronary stents. Adds "for intracoronary stents" to effective date of November 1, 1996. Adds effective date of April 24, 2003 for coverage of drug eluting stents.

13. Section 11.1 (**Hemic and Lymphatic Systems**). Adds new CPT codes 37765, 37766, 38204-38215 and 38242 to procedure code range. New procedure code range is 37765, 37766, 38100-38200, 38204-38242, 38300-38999.

14. Section 13.2 (**Surgery for Morbid Obesity**). Clarifies that laparoscopic bariatric surgical procedures for morbid obesity is excluded from coverage.

15. Section 14.1 (**Urinary System**). New CPT codes 50543, 50562, 51701-51703, and 53500 are within current procedure code range. New CPT code 50542 (cryotherapy for ablation of renal cell carcinoma) is considered unproven and is added to EXCLUSIONS. The new procedure code range is 50010-50541, 50543-53899, 64561, 64581, 64585, 64590, and 64595.

16. Section 18.2 (**Antepartum Services**). Adds new CPT codes 59070, 59072, 59074, and 59076. New procedure code range is 59000-59051, 59070, 59072, 59074, and 59076.

SUMMARY OF CHANGES (Continued)

CHAPTER 4 (Continued)

17. Section 20.1 (**Nervous System**). Adds CPT codes 95961 and 95962. New procedure codes 61537, 61540, 61566, 61567, 61863-61868, 63101-63103, 64449, 64517, and 64681 are within current procedure code range. CPT codes 61862 and 99211-99215 deleted. New procedure code range is 61000-61860, 61863-64999, 95961, 95962, and 95970-95975. Removes transcatheter hepatic arterial embolization from EXCLUSIONS.

18. Section 22.2 (**Cochlear Implantation**). New procedure codes 92601-92604 added to procedure code range. New procedure code range is 69930, 92510, and 92601-92604.

19. Section 23.1 (**High Dose Chemotherapy and Stem Cell Transplantation**). Removes metastatic breast cancer as a covered indication for high dose chemotherapy with autologous bone marrow or autologous peripheral stem cell transplantation. Adds Hodgkin's disease as a covered indication for allogeneic stem cell transplantation.

20. Section 24.5 (**Liver Transplantation**). Adds new CPT codes 47140-47142. New procedure code range is: 47133-47136 and 47140-47142.

CHAPTER 5

21. Section 1.1 (**Diagnostic Radiology (Diagnostic Imaging)**). New procedures codes 70557, 70558, 70559, 75998, 76082, and 76083 are within current procedure code range. New procedure code range is: 70010-76083, 76086-76394, 76400, and 76496-76499. Adds MRIs (CPT codes 76093 and 76094) to confirm implant rupture in symptomatic patients whose ultrasonography shows rupture, to screen for breast cancer, to evaluate breasts before biopsy, to differentiate benign from malignant breast disease and to differentiate cysts from solid lesions to EXCLUSIONS.

22. Section 2.1 (**Diagnostic Ultrasound**). New CPT codes 76937 and 76940 are within current procedure code range. New CPT code 76514 for Corneal Pachymetry is covered effective with the start date of the new contracts.

CHAPTER 6

23. Section 1.1 (**General**). New CPT codes 84156, 84157, 85055, 85396, 87269, 87329, 87660, 88112, 88361, 89220, 89225, 89230, 89235, and 89240 are within current procedure code range. New CPT codes 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342 -89344, 89346, 89352 - 89354, and 89356 are added to EXCLUSIONS.

CHAPTER 7

24. Table of Contents (**Medicine**). Adds Special Otorhinolaryngologic Services.

SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

25. Section 2.1 (**Clinical Preventive Services-TRICARE Standard**). Removes "NOTE: The procedure codes in this policy are not necessarily an all-inclusive list of vaccines currently recommended by CDC's Advisory Committee on Immunization Practices (ACIP)." As the policy provides for coverage of immunizations for the age appropriate dose of vaccines recommended and adopted by CDC's Advisory Committee on Immunization Practices, specific CPT codes for immunizations have been removed and will not be listed.

26. Section 2.2 (**Clinical Preventive Services-TRICARE Prime**). Deletes CPT codes 99381 and 99391 from comprehensive health promotion and disease prevention exams because these codes are for age under 1 year. These codes are covered under Chapter 7, Section 2.5 (Well-Child Care). Deletes CPT code 76085 and HCPCS code G0203 from Mammography. Adds CPT code 76083 and HCPCS codes G0204 and G0206 to Mammography. Adds new CPT codes 88174 and 88175 to Papanicolaou smears. Revises Relevant CPT Code for Breast Cancer-Physical Examination, Cancer of Female Reproductive Organs-Physical Examination, Testicular Cancer-Physical Examination, Prostate Cancer-Physical Examination, Colorectal Cancer-Physical Examination, Skin Cancer-Physical Examination, Oral Cavity and Pharyngeal Cancer-Physical Examination, Thyroid Cancer-Physical Examination, Cardiovascular Diseases-Blood pressure screening, and Other-Body Measurement to "See appropriate level evaluation and management codes."

27. Section 2.5 (**Well-Child Care**). Adds CPT codes 92585, 92586, 92587 to procedure code range. Adds NOTE: Newborn hearing screening within the first 3 months of life and preferable before hospital discharge, using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing. New procedure code range is: 54150, 54160, 81000-81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 86585, 90471-90474, 90476-90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585-92588, 99172, 99173, 99381-99383, 99391-99393, 99431, 99433, 99499.

28. Section 3.3 (**Preauthorization Requirements for Acute Hospital Psychiatric Care**). Adds effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. Once Medicare inpatient mental health benefits have been exhausted, TRICARE's preadmission and continued stay requirements apply.

29. Section 3.5 (**Preauthorization Requirements for Substance Use Disorder Detoxification and Rehabilitation**). Adds effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. Once Medicare inpatient mental health benefits have been exhausted, TRICARE's preadmission and continued stay requirements apply.

SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

30. Section 3.6 (**Psychiatric Partial Hospitalization Programs-Preauthorization and Day Limits**). Adds effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. Once Medicare inpatient mental health benefits have been exhausted, TRICARE's preadmission and continued stay requirements apply.

31. Section 3.12 (**Psychological Testing**). Adds NOTE: Psychological tests are considered diagnostic services and are not counted against the 2 psychotherapy visits per week. Copay for retirees and their dependents would be $12.00 per visit.

32. Section 3.15 (**Psychotropic Pharmacologic Management**). Adds NOTE: Office visits for psychotrophic pharmacologic management are routine medical services and do not count against the 2 visits per week or the initial 8 visits for psychotherapy.

33. Section 8.1 (**Special Otorhinolaryngologic Services**). Changes section name from Audiology Service to Special Otorhinolaryngologic Services. Eighteen new codes are added, three are deleted, and one code is revised to the Special Otorhinolaryngologic Services subsection. This revision does not represent a new benefit. The purpose is to be consistent with the CPT format. New CPT codes are: 92601-92617 and 92700. The procedure code range is 92502-92512, 92516, 92520, 92526, 92551-92597, 92601-92617 and 92700. CPT codes 92590-92596 and 92605-92609 are coverable only for eligible beneficiaries through the Program for Persons with Disability.

34. Section 16.2 (**Health and Behavior Assessment/Intervention**). Removes procedure code 96155 from procedure code range in paragraph I. Family evaluation and assessment (without the patient present) (CPT 96155) is excluded. New procedure code range is: 96150-96154.

35. Section 22.1 (**Telemedicine/Telehealth**). Removes "through December 31, 2002" from paragraph II.B.2. and adds "during calendar year"; changes originating site fee to $20.60 and adds 2004 MEI Increase and Facility Fees to Figure 7-22.1-1.

CHAPTER 8

36. Table of Contents (**Other Services**). Adds Section 2.4 (Cold Therapy Devices for Home Use).

37. Section 2.4 (**Cold Therapy Devices for Home Use**). Adds section on cold therapy devices which had been deleted from previous edition of Policy Manual. Policy on cold therapy devices revised to clarify that cold therapy devices are excluded from coverage (1) as durable medical equipment (DME) with deluxe, luxury, or immaterial features; and (2) comfort and convenience item.

SUMMARY OF CHANGES (Continued)

CHAPTER 8 (Continued)

38. Section 4.1 (**Prosthetic Devices**). Inserts the following sentence to paragraph III.B.: "The purchase of prosthetic devices includes artificial limbs, eyes, and as of October 5, 1994, voice prostheses to include mechanical hand-held voice prostheses." This is not a new benefit. This is only reinserting language that have been removed from previous editions to the Policy Manual.

39. Section 5.1 (**Medical Devices**). Adds devices with a FDA-approved IDE categorized by the FDA as non-experimental/investigational (FDA Category B), which was the subject of an FDA approved clinical trial(s), may be considered for coverage once it receives FDA approval for commercial marketing. Coverage is dependent on the device meeting the FDA requirements/conditions of approval and all other requirements governing TRICARE.

CHAPTER 10

40. Section 3.1 (**Prime and Status Changes**). Adds for those newborns and adoptees who are covered under the 120 day "deemed enrollment" benefit, process these claims as civilian Prime for this period. If the newborn or adoptee is formally enrolled during this period, process using enrollment status. If the newborn or adoptee is not formally enrolled during the 120 day calendar day period, at the end of the 120 calendar day period, the contractor shall process all claims as a non-enrolled beneficiary, applying the appropriate TRICARE cost-share and deductibles.

CHAPTER 11

41. Section 3.3 (**Accreditation**). Replaces the reference to the Council on Postsecondary Accreditation (COPA) with the correct and current reference to the Council on Higher Education Accreditation (CHEA) and adds the correct address and phone number for CHEA.

42. Section 9.1 (**Other Provider Certification**). Adds "durable medical equipment" to paragraph II.B. Adds any firm, supplier, or provider that is authorized under Medicare. Adds "for those listed that are not Medicare-authorized" to paragraph II.B.2.

SUMMARY OF CHANGES

CHAPTER 12

43. Section 1.1 (**Introduction**). Adds "30 days and over" to the first sentence in paragraph V.F. Revises the first sentence in paragraph V.G. to: Stateside/overseas enrolled Reserve or National Guard under a Presidential recall or activated 30 days and over overseas who obtain overseas care claims shall be processed by the overseas MCSC. Adds paragraph V.H.-Reservists on orders for less than 30 days, who are injured while traveling to or from annual training who receive civilian medical care OCONUS, claims should be processed by the reserve members unit. For countries covered under the TGRO contract, reservists, who are injured while traveling to or from annual training, who receive urgent/emergent care facilitated by the TGRO contractor, claims shall be submitted by the TGRO contractor to the overseas MCSC responsible for processing foreign claims.

44. Section 3.1 (**Eligibility Requirements**). Removes "all" from the second sentence in paragraph I.

45. Section 3.3 (**Prime and Status Changes**). Adds for those newborns who are covered under the 120 day "deemed enrollment" benefit, process these claims as civilian Prime for this period. If the newborn is formally enrolled during this period, process using enrollment status. If the newborn is not formally enrolled during the 120 day calendar period, at the end of the 120 calendar day period, the contractor shall process all claims as a non-enrolled beneficiary, applying the appropriate TRICARE cost-share and deductibles.

46. Section 8.1 (**Authorization Requirements**). Adds "PFPWD benefits are not administered under the TGRO program" to paragraph I.A. Removes "by Military Medical Support Office (MMSO)" from paragraph I.E. Adds "For TOP enrolled ADFM and TOP standard beneficiaries" to beginning of paragraph I.F.

47. Section 10.1 (**Payment Policy**). Adds Philippines to paragraph I.D. Revises paragraph I.F. to: TGRO contractor claims submitted for ADFMs not enrolled in TOP Prime shall be denied. The overseas MCSC's EOB shall advise the TGRO contractor that the beneficiary was not enrolled in TOP Prime. Adds paragraph I.I.: Payment may be made for TGRO contractor ambulance services provided by commercial transport. (See Chapter 12, Section 11.1 for additional guidance on processing these claims.)

48. Section 10.2 (**Point of Service (POS) Option (Prime)**). Adds third sentence to paragraph III.A. as follows: "TOP Prime Point of Service cost-share may apply for inpatient non-urgent/emergent mental health care received without an authorization (see Chapter 12, Section 11.1)."fa

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

49. Section 11.1 (**Managed Care Support Contractor (MCSC) Responsibilities for Claims Processing**). Revises paragraph I.F. to: "Unless otherwise stated, the requirements provided in this chapter shall apply to Stateside MCSC Regions when processing overseas claims for beneficiaries enrolled or residing in these MCS contract regions." Changes monthly charges to weekly charges in the second sentence, paragraph IV.1.e.(2)(a). Adds "When TGRO claims cannot be submitted electronically, the TGRO contractor shall request a waiver from the government POC" to paragraph V.D.2. Adds "including TGRO contractor claims" to paragraph V.D.6. Adds paragraph V.D.11: "Reservists on orders for less than 30 days, who are injured while traveling to or from annual training who receive civilian medical care OCONUS, claims should be processed by the reserve members unit. For countries covered under the TGRO contract, reservists, who are injured while traveling to or from annual training, who receive urgent/emergent care facilitated by the TGRO contractor, claims shall be submitted by the TGRO contractor to the overseas MCSC responsible for processing foreign claims." Adds new paragraph V.E.10: "The TGRO contractor shall also request separate provider numbers for the billing of commercial air transports." Adds paragraph V.H.7: "For TGRO claims, itemization of total charges for commercial air transports are not required." Adds "For TGRO claims, the contractor shall consider DME as authorized and not require usual information necessary to process the claim" to paragraph V.H.1.f. Adds paragraph V.I.17: "TGRO claims related to ambulance services are not required to be submitted using modifier codes for ambulance services." Adds paragraph V.I.18: "TGRO claims either denied as 'beneficiary not eligible' or found to be not eligible on DEERS, shall request a 'good faith payment' from the Beneficiary and Provider Services, 16401 East Centretech Parkway, Aurora, CO 80011." To paragraph V.Q.1.a. adds: "For professional services rendered in the Philippines, reimbursement shall be the lower of the billed amount or the CMACs established for Puerto Rico. The balance billing provision will be applied in the Philippines for nonparticipating providers." Changes the title of table to Enrolled/Non-Enrolled ADSM Under Presidential Recall or Activated Overseas, Greater Than 30 Days, Deployed, TDY, Or On Leave. Adds "for urgent/emergent care only" to tables on pages 26 and 27.

50. Section 12.2 (**Figures**). Revises list of countries in Figure 12-12.2-4 List of Overseas Remote, Non-Remote, & MTF Countries by Region. Adds "When Submitting Paper Claims" to title of Figure 12-12.2-15.